Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Russell Jepson, DC

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-14-3551-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 4, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We requested a reconsideration from the insurance, Texas Mutual, for a claim … for date of service 04/04/2014 in the amount of $1200.00, for a Designated Doctor Exam. We received partial payment of $1050.00. We submitted a reconsideration request on 07/08/2014, for the remaining balance of $150.00. The denial reason(s) per EOB are: Workers Compensation fee schedule adjustment. Designated Doctor Exams are billed according to DWC rule 134.204 and accordance with labor code 408.004, 408.041, and 408.151."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor used the DRE method to assign impairment. Texas Mutual paid the MAR for this method. No additional payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 4, 2014	Designated Doctor Exam to Determine Impairment Rating	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 (j)(4) defines the billing and reimbursement procedures for evaluation of Impairment Rating.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-W1 – Workers Compensation State Fee Schedule adjustment.
   - 790 – This charge was reimbursed in accordance with the Texas Medical Fee Guideline.
   - CAC-P12 – Workers' Compensation jurisdictional fee schedule adjustment.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was

processed properly.

- 724 – No additional payment after a reconsideration of services. For information call 1-800-937-6824

Issues

1. What is the total allowable amount for the impairment rating of the spine?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation. (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (ii) The MAR for musculoskeletal body areas shall be as follows. (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used. (II) **If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area**; and (-b-) $150 for each additional musculoskeletal body area" [emphasis added]. The provider supplied a report with a full physical evaluation with range of motion to determine Impairment Rating. The provider stated, "Based on Page 99 from the AMA Guides to the Evaluation of Permanent Impairment, 4th edition, the Range of Motion Differentiator was utilized in determining placement of the examinee into the correct DRE Category … Range of Motion was performed and utilized for this evaluation."
2. The division concludes that the total allowable for the impairment rating of the spine is $300.00. The respondent issued payment in the amount of $150.00 for the IR of the spine. Based upon the documentation submitted, additional reimbursement in the amount of $150.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	December 18, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.